SUNRISE PEDIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization to release information is being requested of you to comply with the terms of the Health Insurance Portability and Accountability Act of 1996.

Patient's Name:_____ Birthdate:_____

Patient's Name:_____ Birthdate:_____

I hereby authorize: Name/ Address/ and Contact Numbers

Sunrise Pediatrics
11920 Westheimer Rd, Suite E
Houston, TX 77077
Phone Number: (281) 679-6165
Fax: (281) 670-5790

To release information to:

_____

_____

_____

Number:_____ Fax:_____

This release limits disclosure to: (Check one) [] All records [] Immunization record only [] Test results

This information is required for: (Please Check one)

[ ] Treatment
[ ] Personal Use
[ ] Continuation of Care
[ ] Legal Use

Print Name of parent/Guardian:_____
(Or patient, if over age of 18)

Signature:_____

Contact Number:_____ **Date:**_____